DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

CORRECTED --- 5-30-01

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 0 4

2. STATE: Arkansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 702 of the BIPA

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 601,813.00
b. FFY 2002 $ 798,242.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Please see attached listing

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Please see attached listing

10. SUBJECT OF AMENDMENT:
The Arkansas Title XIX State Plan has been amended to reflect a revision in the reimbursement methodology for Rural Health Clinics and Federally Qualified Health Centers.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Ray Hanley by dlt

13. TYPED NAME:
Ray Hanley

14. TITLE:
Director, Division of Medical Services

15. DATE SUBMITTED:
March 27, 2001

16. RETURN TO:
Division of Medical Services
P. O. Box 1437
Little Rock, AR 72203-1437

Attention: Binnie Alberius
Slot 1103

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
March 27, 2001

18. DATE APPROVED:
April 25, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Calvin C. Clark

22. TITLE:
Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

ATTACHED LISTING FOR
ARKANSAS STATE PLAN
TRANSMITTAL #2001-004

8. Number of the Plan Section or Attachment	9. Number of the Superseded Plan Section or Attachment
Attachment 4.19-B, Page 1aaa	Attachment 4.19-B, Page 1aaa Approved 11-29-00, TN 00-10
Attachment 4.19-B, Page 1aaaa	None, New Page
Attachment 4.19-B, Page 1b	~~None, New Page~~
Attachment 4.19-B, Page 1bb	None, New Page
Attachment 4.19-B, Page 1bbb	None, New Page
Attachment 4.19-B, Page 1bbbb	None, New Page
Attachment 4.19-B, Page 1c	Attachment 4.19-B, Page 1b Approved 08-26-98, TN 98-10
Attachment 4.19-B, Page 1cc	Attachment 4.19-B, Page 1c Approved 02-12-01, TN 00-16

2.b. Rural Health Clinic Services and other ambulatory services that are covered under the plan and furnished by a rural health clinic.

In accordance with Section 1902(aa) of the Social Security Act as amended by the Benefits Improvement and Protection Act (BIPA) of 2000, effective for dates of service occurring January 1, 2001 and after, payments to Rural Health Clinics (RHCs) for Medicaid covered services will be made using a prospective payment system (PPS) based on a per visit basis. A visit means a face-to-face encounter between an RHC patient and any health professional whose services are reimbursed under the State Plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

The PPS per visit rate for each facility will be calculated based on 100 percent of the average of the facility's reasonable costs for providing Medicaid covered services as determined from audited Medicare cost reports with ending dates in calendar year 1999 and calendar year 2000. Reasonable costs are defined as those costs which are allowable under Medicare cost principles outlined in 42 CFR 413 with no lesser of costs or charges limits and no per visit payment limit. Cost reports used for rate setting purposes must cover a fiscal period of at least a full six months. If a provider has more than one cost report period ending in the same calendar year, Arkansas Medicaid will use the most recent cost report to calculate rates. Adjustments to the Medicare RHC Program allowable costs per the cost report may be necessary due to differences with Medicaid Program covered services.

PPS per visit rates will be calculated by adding the total audited allowable costs as determined from the 1999 and 2000 cost reports and dividing the total by the total audited visits for these same two periods. Until audited cost report information is available, interim rates will be implemented as of January 1, 2001 at the average cost per visit as determined from the two most recent provider cost reports. Interim rates will be calculated by adding the two period's per visit costs and dividing the total by two. Interim rates will be retroactively adjusted to January 1, 2001, when audited cost report information becomes available and final rates are calculated.

Each facility's PPS per visit rate will be adjusted to account for increases or decreases in scope of services. Scope of services changes are defined as 1) an addition or deletion of an RHC covered service, 2) a change in the magnitude, intensity, or character of currently offered RHC covered services, 3) a change in regulatory requirements 4) a change due to relocation, remodeling, opening a new clinic site or closing an existing clinic site, 5) a change in applicable technologies and medical practices, or 6) a change due to recurring taxes, malpractice insurance premiums or workmens comp. insurance premiums that were not recognized and included in the base year's rate calculation. Written requests for both cost increases and cost decreases due to scope of services changes must be submitted by the provider. The request must be submitted (postmarked) within 5 months after the end of the provider's fiscal period and the request must identify the beginning date that the change occurred and include detailed descriptions, documentation and calculations of the changes and costs differences.

2.b. Rural Health Clinic Services and other ambulatory services that are covered under the plan and furnished by a rural health clinic (Continued)

In order to qualify for a PPS rate change, the scope of services changes must equal to at least a 5% total difference in the allowable per visit cost as determined for the fiscal period and the changes must have existed during the last full 6 month period of the fiscal period. Arkansas Medicaid will review the submitted documentation and will notify the provider within 90 days as to whether a PPS rate change will be implemented. If implemented, the PPS rate change will reflect the cost difference of the scope of service change and be effective as of the later of the first date that the scope of service changed or the beginning date of the fiscal period. PPS rate changes will also be made due to scope of service changes identified through an audit or review process. If this occurs, the effective date of the PPS rate change will be the later of the first date that the scope of services changed or the beginning date of the cost report period for which the changes should have been reported.

Independent (Freestanding) RHCs that do not have minimal 1999 and 2000 cost report periods (at least 6 months) or who enroll in Medicaid after 2000, will have their initial PPS per visit rate established at the average of the current rates of the three nearest independent RHCs with similar caseloads. Nearest will be determined per map mileage. A final PPS per visit rate shall be established using the facility's allowable costs as determined from the provider's first two audited cost reports with reporting periods of at least a full six months. The final PPS rate will be made effective as of the first day after the provider's second fiscal cost report period used for rate setting.

Provider based RHCs that do not have minimal 1999 and 2000 cost report periods (at least six months) or who enroll in Medicaid after 2000 will have their initial PPS per visit rate established at the average of the current rates of the provider hospital's other enrolled RHCs with similar caseloads. Should a newly enrolled provider based RHC be the only clinic operated by the hospital, the initial PPS rate shall be established at the average of the current rates of the three nearest provider based RHCs with similar caseloads. Nearest will be determined per map mileage. A final PPS per visit rate shall be established using the facility's allowable costs as determined from the provider's first two audited cost reports with reporting periods of at least a full six months. The final PPS rate will be made effective as of the first day after the provider's second fiscal cost report period used for rate setting.

Beginning July 1, 2001, interim rates, initial PPS rates and final PPS rates will annually be adjusted as of July 1st of each year by the regional Medicare Economic Index (MEI) for primary care services. Rate adjustments will be equal to the previous calendar year's index percentage change.

SUPERSEDES: NONE - NEW PAGE

STATE Arkansas	A
DATE REC'D 03-27-01	
DATE APPV'D 06-25-01	
DATE EFF 01-01-01	
HCFA 179 AR-01-04	

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

For FQHC Facilities Agreeing To The Alternative Payment Methodology

Written and signed agreements will be obtained from all FQHC providers who choose this alternative method.

In accordance with Section 1902(aa) of the Social Security Act as amended by the Benefits Improvement and Protection Act (BIPA) of 2000, effective for dates of service occurring January 1, 2001 and after, FQHCs will be reimbursed an interim per visit rate for Medicaid covered services with cost settlement at the greater of 100% of reasonable costs or the allowable per visit rate as determined under the prospective payment system (PPS). Cost settlement will be determined from provider submitted cost reports. Separate cost settlements will be made for cost reporting periods with dates of service occurring before and beginning January 1, 2001 based on the number of Medicaid visits provided before and beginning January 1, 2001. A visit means a face-to-face encounter between an FQHC patient and any health professional whose services are reimbursed under the State Plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

The PPS per visit rate for each facility will be calculated based on 100 percent of the average of the facility's reasonable costs for providing Medicaid covered services as determined from audited cost reports with ending dates in calendar year 1999 and calendar year 2000. Reasonable costs are defined as those costs which are allowable under Medicare cost principles outlined in 42 CFR 413 with no lesser of costs or charges limits and no per visit payment limit. Cost reports used for rate setting purposes must cover a fiscal period of at least a full six months. If a provider has more than one cost report period ending in the same calendar year, Arkansas Medicaid will use the most recent cost report to calculate rates.

PPS per visit rates will be calculated by adding the total audited allowable costs as determined from the 1999 and 2000 cost reports and dividing the total by the total audited visits for these same two periods. Interim rates will be implemented as of January 1, 2001 at the average cost per visit as determined from the two most recent provider cost reports. Interim rates will be calculated by adding the two period's per visit costs and dividing the total by two. Providers may request reductions of up to 20% of their January 1, 2001 interim rates by submitting a written request within 21 days after notification by Medicaid of their new interim rate. Thereafter, interim rates will be established at the allowable cost per visit as determined from the most recent audited cost report and will be effective as of the first day after the audited cost report period. Providers may also request reductions of up to 10% of these interim rates by submitting a written request within 21 days after notification by Medicaid of their new interim rate.

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4) (continued).

Each facility's PPS per visit rate will be adjusted to account for increases or decreases in scope of services. Scope of services changes are defined as 1) an addition or deletion of an FQHC covered service, 2) a change in the magnitude, intensity, or character of currently offered FQHC covered services, 3) a change in regulatory requirements, 4) changes due to relocation, remodeling, opening a new clinic site or closing an existing clinic site, 5) a change in applicable technologies and medical practices, or 6) a change due to recurring taxes, malpractice insurance premiums or workmens comp. insurance premiums that were not recognized and included in the base year's rate calculation. Written requests for both cost increases and cost decreases due to scope of services changes must be submitted by the provider. The request must be submitted (postmarked) within 5 months after the end of the provider's fiscal period and the request must identify the beginning date that the change occurred and include detailed descriptions, documentation and calculations of the changes and costs differences. In order to qualify for a PPS rate change, the scope of services changes must equal to at least a 5% total difference in the allowable per visit cost as determined for the fiscal period and the changes must have existed during the last full 6 month period of the fiscal period. Arkansas Medicaid will review the submitted documentation and will notify the provider within 90 days as to whether a PPS rate change will be implemented. If implemented, the PPS rate change will reflect the cost difference of the scope of service change and be effective as of the later of the first date that the scope of service changed or the beginning date of the fiscal period. PPS rate changes will also be made due to scope of service changes identified through an audit or review process. If this occurs, the effective date of the PPS rate change will be the later of the first date that the scope of services changed or the beginning date of the cost report period for which the changes should have been reported .

FQHCs that do not have minimal 1999 and 2000 cost report periods (at least 6 months) or who enroll in Medicaid after 2000, will have their initial PPS per visit rate established at the average of the current rates of the three nearest FQHCs with similar caseloads. Nearest will be determined per map mileage. A final PPS per visit rate shall be established using the facility's allowable costs as determined from the provider's first two audited cost reports with reporting periods of at least a full six months. The final PPS rate will be made effective as of the first day after the provider's second fiscal cost report period used for rate setting.

Effective for provider fiscal periods beginning January 1, 2001 and after, interim rates, initial PPS rates and final PPS rates will annually be adjusted as of the first day of the provider's fiscal period by the regional Medicare Economic Index (MEI) for primary care services. Rate adjustments will be equal to the previous calendar year's index percentage change.

SUPERSEDES: NONE - NEW PAGE

STATE	Arkansas
DATE REC'D	03-27-01
DATE APP'VD	06-25-01
DATE EFF	01-01-01
HCFA 179	AR-01-04

A

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4) (continued).

For FQHC Facilities Not Agreeing To The Alternative Payment Methodology

In accordance with Section 1902(aa) of the Social Security Act as amended by the Benefits Improvement and Protection Act (BIPA) of 2000, effective for dates of service occurring January 1, 2001 and after, payments to Federally Qualified Health Centers (FQHCs) for Medicaid covered services will be made using a prospective payment system (PPS) based on a per visit basis. A visit means a face-to-face encounter between an FQHC patient and any health professional whose services are reimbursed under the State Plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

The PPS per visit rate for each facility will be calculated based on 100 percent of the average of the facility's reasonable costs for providing Medicaid covered services as determined from audited cost reports with ending dates in calendar year 1999 and calendar year 2000. Reasonable costs are defined as those costs which are allowable under Medicare cost principles outlined in 42 CFR 413 with no lesser of costs or charges limits and no per visit payment limit. Cost reports used for rate setting purposes must cover a fiscal period of at least a full six months. If a provider has more than one cost report period ending in the same calendar year, Arkansas Medicaid will use the most recent cost report to calculate rates.

PPS per visit rates will be calculated by adding the total audited allowable costs as determined from the 1999 and 2000 cost reports and dividing the total by the total audited visits for these same two periods. Until audited cost report information is available, interim rates will be implemented as of January 1, 2001 at the average cost per visit as determined from the two most recent provider cost reports. Interim rates will be calculated by adding the two period's per visit costs and dividing the total by two. Interim rates will be retroactively adjusted to January 1, 2001, when audited cost report information becomes available and final rates are calculated.

Each facility's PPS per visit rate will be adjusted to account for increases or decreases in scope of services. Scope of services changes are defined as 1) an addition or deletion of an FQHC covered service, 2) a change in the magnitude, intensity, or character of currently offered FQHC covered services, 3) a change in regulatory requirements 4) a change due to relocation, remodeling, opening a new clinic site or closing an existing clinic site, 5) a change in applicable technologies and medical practices, or 6) a change due to recurring taxes, malpractice insurance premiums or workmens comp. insurance premiums that were not recognized and included in the base year's rate calculation.

NOTE - NEW PAGE

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4) (continued).

Written requests for both cost increases and cost decreases due to scope of services changes must be submitted by the provider. The request must be submitted (postmarked) within 5 months after the end of the provider's fiscal period and the request must identify the beginning date that the change occurred and include detailed descriptions, documentation and calculations of the changes and costs differences. In order to qualify for a PPS rate change, the scope of services changes must equal to at least a 5% total difference in the allowable per visit cost as determined for the fiscal period and the changes must have existed during the last full 6 month period of the provider's fiscal period. Arkansas Medicaid will review the submitted documentation and will notify the provider within 90 days as to whether a PPS rate change will be implemented. If implemented, the PPS rate change will reflect the cost difference of the scope of service change and be effective as of the later of the first date that the scope of service changed or the beginning date of the fiscal period. PPS rate changes will also be made due to scope of service changes identified through an audit or review process. If this occurs, the effective date of the PPS rate change will be the later of the first date that the scope of services changed or the beginning date of the cost report period for which the changes should have been reported .

FQHCs that do not have minimal 1999 and 2000 cost report periods (at least 6 months) or who enroll in Medicaid after 2000, will have their initial PPS per visit rate established at the average of the current rates of the three nearest FQHCs with similar caseloads. Nearest will be determined per map mileage. A final PPS per visit rate shall be established using the facility's allowable costs as determined from the provider's first two audited cost reports with reporting periods of at least a full six months. The final PPS rate will be made effective as of the first day after the provider's second fiscal cost report period used for rate setting.

Beginning July 1, 2001, interim rates, initial PPS rates and final PPS rates will annually be adjusted as of July 1st of each year by the regional Medicare Economic Index (MEI) for primary care services. Rate adjustments will be equal to the previous calendar year's index percentage change.

3. Laboratory and X-ray Services

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. The Title XIX (Medicaid) maximum is 66% of the Physician's Blue Shield Fee Schedule dated October 1, 1993.

At the beginning of each calendar year, the State Agency will negotiate with the affected provider group representatives to arrive at a mutually acceptable increase or decrease from the maximum rate. Market forces, such as private insurance rates, medical and general inflation figures, changes in practice costs and changes in program requirements, will be considered during the negotiation process. Any agreed upon increase or decrease will be implemented at the beginning of the following State Fiscal Year, July 1, with any appropriate State Plan changes.

(1) Clinical Laboratory Services

Reimbursement for clinical laboratory services will be equal to Medicare.

(2) Portable X-ray Services

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. The Title XIX (Medicaid) maximum is 66% of the Physician's Blue Shield Fee Schedule dated October 1, 1993.

At the beginning of each calendar year, the State Agency will negotiate with the affected provider group representatives to arrive at a mutually acceptable increase or decease from the maximum rate. Market forces, such as private insurance rates, medical and general inflation figures, changes in practice costs and changes in program requirements, will be considered during the negotiation process. Any agreed upon increase or decrease will be implemented at the beginning of the following State Fiscal year, July 1, with any appropriate State Plan changes.

(3) Chiropractor X-ray Services

Effective for dates of service on or after June 1, 1998, the Arkansas Medicaid maximum for an X-ray will be calculated by using the average of the 1997 Medicare Physician's Fee Schedule (participating fee) rates at 100% for the complete components for procedure codes 72010, 72040, 72050, 72070, 72100 and 72110; or such procedure codes implemented by Medicare, as the AMA (or it's successor) shall declare are the replacements for, and successor's thereto. The average rate will be established as the Medicaid maximum for procedure code Z1928 (Chiropractic X-ray), or such procedure code implemented by Arkansas Medicaid for the purpose of billing a Chiropractic X-ray.

Effective for dates of service on or after July 1 of each year, Arkansas Medicaid will apply an adjustment factor to the Medicaid maximum. To determine the adjustment factor a comparison between the previous and current year's Medicare rates will be made. The adjustment factor will be equal to the average adjustment made to the Medicare payment rates, for all of the above CPT radiology procedure codes, as reflected in the current Medicare Physician's Fee Schedule.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Revised: January 1, 2001

4.a. Nursing Facility Services (other than services in an institution for mental diseases) for individuals 21 Years of Age or Older - SEE ATTACHMENT 4.19-D

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found.

(1) Reimbursement for Child Health Services (EPSDT) is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum.